Appendix 12
Endodontic Services

Please note that local anesthesia is included in the fee for procedures requiring anesthesia and is not separately billable. When a provider uses anesthesia, the anesthesia charge should be included in the amount billed for the procedure.

Proc. Code	Description of Service	PA Required?	Allowable Age	Limitations
Pulpotomy:				
03220	Therapeutic pulpotomy (excluding final restoration)	No	All	Once per tooth per lifetime. Primary teeth only. (tooth letters A-T, SN only)
Root Canal Therapy (including treatment plan, clinical procedures, and follow-up care:				
03310	Anterior (excluding final restoration)	Yes, > age 20	All	Normally for permanent anterior teeth. May be used to bill a single canal on a bicuspid or molar (tooth numbers 2-15, 18-31, SN only, once per tooth, per lifetime). Not allowed with sedative filling.
03320	Bicuspid (excluding final restoration)	Yes, > age 20	All	Normally for permanent bicuspid teeth May be used for two canals on a molar (tooth numbers 2-5, 12-15, 18-21, 28-31, SN only, once per tooth, per lifetime). Not allowed with sedative filling.
03330	Molar (excluding final restoration)	Yes	All	Not covered for third molars. Permanent teeth only (tooth numbers 2, 3, 14, 15, 18, 19, 30, 31, SN only, once per tooth, per lifetime). Not allowed with sedative filling.
03351	Apexification/recalcification - (apical closure/calcific repair of perforations, root resorption, etc.)	No	< 21	Permanent teeth only (tooth numbers 2-15, 18-31, SN only). Not allowable with root canal therapy. Bill the entire procedure under this code.

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Endodontic Services
(continued)

Proc. Code	Description of Service	PA Required?	Allowable Age	Limitations
W7116	Open tooth for drainage	No	All	Tooth numbers 2-15, 18-31, SN. *Emergency only.* Limit of $50.00 reimbursement per day for all emergency procedures done on a single day. Narrative required to override the limitations. Not billable with root canal therapy or pulpotomy on same date of service. Should be followed with a prior authorization request for a root canal.
Periapical Services:				
03410	Apicoectomy/periradicular surgery - anterior	Yes, unless provided to a hospital inpatient	All	Permanent anterior teeth only (tooth numbers 6-11, 22-27, SN only). Not payable with root canal therapy on the same date of service. Code does not include retrograde filling. Include retrograde filling on prior authorization request for apicoectomy and on claim for billing.
03430	Retrograde filling - per root	Yes, unless provided to a hospital inpatient		Permanent anterior teeth only (tooth numbers 6-11, 22-27, SN only). Not payable with root canal therapy for the same date of service. Include retrograde filling on prior authorization request for apicoectomy and on claim for billing. Apicoectomy does not include retrograde filling.

Appendix 12
Endodontic Services
(continued)

COVERED SERVICES

STANDARDS FOR ROOT CANAL THERAPY

The following guidelines must be followed when providing endodontic services:

- The standard of acceptability employed by Wisconsin Medicaid for endodontic procedures requires that the canal(s) be completely filled apically and laterally.
- Root canal therapy for permanent teeth includes:

1. Diagnosis.
2. Extirpation.
3. Treatment.
4. Progress radiographs.
5. Filling and obliteration of root canals.
6. Temporary fillings.

NONCOVERED SERVICES

When the root canal filling does not meet Wisconsin Medicaid treatment standards:

- Wisconsin Medicaid can require the procedure to be redone at no additional Wisconsin Medicaid reimbursement.
- Any reimbursement already made may be recouped after the Wisconsin Medicaid dental consultant reviews the circumstances.

Sargenti filling material and other materials not accepted by the federal Food and Drug Administration are not accepted by Wisconsin Medicaid.

RADIOGRAPHS

A post-treatment radiograph *is required* for all root canal therapy and can be reimbursed separately.

OPEN TOOTH FOR DRAINAGE

Emergency treatment for recipients needing root canal therapy can be provided without prior authorization (PA) using code W7116, (Open Tooth for Drainage). This allows the dentist to relieve pain and/or extirpate the tooth in anticipation of proceeding with a root canal. A PA request for a root canal should be sent immediately.

INTERRUPTED ROOT CANAL THERAPY

A dentist may bill "open tooth for drainage" and "sedative filling" to receive reimbursement when root canal therapy begins and the recipient fails to return for subsequent visits or becomes ineligible.

REFERRALS

General dentists should not refer Medicaid recipients to endodontists, unless the recipient has a restorative dentist to provide restoration of the teeth.

General dentists referring a root canal procedure to an endodontist should complete the appropriate sections of the Prior Authorization Dental Attachment (PA/DA) form and send it to the endodontist with the referral.

General dentists referring Medicaid recipients to endodontists need to supply the endodontist with:

- Minimum of two bitewing x-rays.
- Oral charting of missing teeth.
- Treatment plan including plan for involved tooth.
- Oral hygiene status.

Appendix 12
Endodontic Services
(continued)

- Attendance information.
- Date and reason for any extractions within the past three years.

PRIOR AUTHORIZATION

PRIOR AUTHORIZED ROOT CANAL SERVICES

PA is required for all anterior, bicuspid, and molar teeth for recipients 21 years old and older. For recipients under age 21, PA is only required for molar endodontic procedures.

Up to three root canals can be approved, based on clinical appropriateness and restorability of the teeth. Root canals are limited to once per tooth, per lifetime, unless extenuating circumstances exist. Root canal therapy is not covered on third molars.

APICOECTOMY AND RETROGRADE FILLING

Apicoectomy and retrograde fillings are limited to anterior teeth only.

Providers must include a periapical with any request for PA for apicoectomy and retrograde filling.

Providers must include a request for a retrograde filling separately with the PA requests for an apicoectomy.

PA is not required when the apicoectomy and retrograde filling services are provided to a hospital inpatient.

CRITERIA FOR APPROVAL

The recipient qualifies for root canal therapy if:

For procedure code 03310

1. No more than three anterior teeth require root canal therapy, and no anterior tooth in the same arch is missing or indicated for extraction. The recipient must have adequate posterior occlusion per Wisconsin Medicaid criteria and would not be a partial denture candidate. If the recipient already qualifies for a partial denture due to missing anterior teeth in the same arch, or inadequate posterior occlusion, the request for root canal therapy is denied and the provider is asked to submit a request for a partial denture. The provider has the option to complete the root canal therapy on the indicated tooth or teeth at the recipient's expense.

2. The tooth is an abutment tooth for a fixed bridge or an anchor tooth for a partial denture and the bridge or partial is serviceable and functional, as determined by the Wisconsin Medicaid dental consultant.

3. Good recipient attendance record.

For procedure codes 03320 and 03330

1. No more than two posterior teeth require root canal therapy, and no anterior tooth in the same arch is missing or indicated for extraction. The recipient must have adequate posterior occlusion per Wisconsin Medicaid criteria and would not be a partial denture candidate. If the recipient already qualifies for a partial denture due to missing anterior

Appendix 12
Endodontic Services
(continued)

teeth in the same arch or inadequate posterior occlusion, the request for root canal therapy is denied and the provider is asked to submit a request for a partial denture. The provider has the option to complete the root canal therapy on the indicated tooth or teeth at the recipient's expense.

2. The tooth is an abutment tooth for a fixed bridge or an anchor tooth for a partial denture and the bridge or partial is serviceable and functional, as determined by the Wisconsin Medicaid dental consultant.

3. One posterior tooth requires root canal therapy and no other anterior tooth or teeth are missing in the same arch, no other tooth or teeth are in need of root canal therapy, and no other tooth or teeth are indicated for extraction. If the denial of the root canal and the resultant tooth extraction qualifies the recipient for a partial denture, and the recipient did not previously qualify for a partial denture, the root canal can be approved.

4. Good recipient attendance record.

Exceptions can be made in the following cases, as determined by the dental consultant:

- Recipients who have post-radiation necrosis potential.
- Blood diseases or disorders where extractions are contraindicated.
- Medically compromised or handicapped recipients.
- Recipients unable to wear complete or partial denture for documented psychiatric reasons.
- Unusual clinical situation where an endodontic procedure appears appropriate based on comprehensive review of the dental plan and medical history. (For example, an irreversible pulpotomy caused by a deep restoration with no other tooth loss within the last three years.).
- Recipients under age 21 who may require more than two molar root canals.
- Recipients under age 21 who may also require a partial denture to replace a missing anterior tooth or teeth.
- To preserve the integrity of an intact arch or quadrant.

CRITERIA USED FOR EVALUATION OF ROOT CANAL THERAPY PRIOR AUTHORIZATION REQUEST

The following criteria are used to evaluate PA requests for root canal therapy:

- Root canal therapy should not be considered for a Medicaid recipient if restoration requires a post and core unless the recipient pays for the post and core. Post and core is not a covered service. If the recipient is unable to pay for the post and core, root canal therapy should not be requested.
- Oral health status and x-rays do not indicate rampant decay; only three anterior teeth or only one bicuspid or molar root canal is necessary.
- Root canal therapy is *not* covered on third molars.
- Root canals performed in anticipation of overlay dentures are not covered.

CRITERIA FOR APICOECTOMY

- An apicoectomy procedure can be approved when an anterior tooth with a failing root canal can be made clinically functional by the procedure.

Appendix 12
Endodontic Services
(continued)

MISSING TEETH EXCLUSIONS

Wisconsin Medicaid's definition of missing teeth *excludes*:

- Wisdom teeth.
- Teeth previously extracted for orthodontic reasons.
- Congenitally missing teeth.
- Teeth lost due to trauma, cancer, or rare tumor.

PRIOR AUTHORIZATION DOCUMENTATION

The provider must submit the following information for root canal therapies:

- Complete intraoral tooth charting and periodontal case type.
- Minimum of two bitewing x-rays and periapical x-ray of involved tooth or teeth.
- Attendance information.
- Indication of oral hygiene status.
- Date and reason for any extractions within the past three years.
- A treatment plan including plan for involved tooth or teeth.
- A good success potential for:
  1. Proper completion of the procedure.
  2. Restoration of the tooth.
  3. Maintenance of the endodontically treated tooth (recipients will maintain their oral health).

DENIAL OF ROOT CANAL THERAPY REQUESTS

If the PA request for root canal therapy is denied, the service is noncovered. The recipient:

- Must be informed in advance of treatment that the service is noncovered.
- May be billed for the service only if PA has been denied and the recipient agrees to pay for the service before the service is provided.

Refer to Section VIII of Part A, the all-provider handbook, for more information.

WISCONSIN MEDICAID NONCOVERED MATERIAL AND SERVICES

Wisconsin Medicaid does not cover the following:

- Filling material not accepted by the federal Food and Drug Administration (FDA) (e.g., Sargenti filling material).
- Root canals performed in anticipation of overlay dentures.
- Post and core. Wisconsin Medicaid covers a root canal needing a post and core only if the recipient agrees in advance to pay for the post and core.

Appendix 12
Endodontic Services
(continued)

BILLING

EMERGENCY SERVICES

Emergency services are defined as services that must be provided immediately to relieve pain, swelling, acute infection, trismus, or trauma. Because the ADA claim form does not have an element to designate emergency treatment, all claims for emergency services must be identified by an "E" in the "For Administrative Use Only" box on the line item for the emergency service of the ADA claim form or element 24I of the HCFA 1500 claim form in order to exempt the services from copayment deduction. *Only the letter "E" without any additional letters is accepted.* Information relating to the definition of a dental emergency is in Section II-A of this handbook.

EMC claims use a different field to indicate an emergency. Refer to your EMC manual for more information.

ADDITIONAL INFORMATION

In addition to this summary, refer to:

- The preceding pages for a complete listing of Medicaid-covered endodontic services, procedure codes, and related limitations.
- Appendix 31 for a summary of required billing documentation.
- Appendix 24 for a summary of required documentation needed for PA requests.